cover test is an exceedingly simple method by which the pediatrician may recognize phorias and possible squinters. A simple amblyopia might also be suspected by this test; or, if found by the visual chart, better explained. Gross refractive errors can be noted in the routine use of the ophthalmoscope. The pediatrician should be as adept with the ophthalmoscope as the internist, and, in addition, somewhat of a contortionist as well.

I was glad to see that the authors mentioned the problem of head-tilting. To me, this is the one point that needs stressing to pediatricians. There have been cases of head-tilting, under the care of reputable pediatricians, who have had needless surgery on the sternocleidomastoideus muscle without results, when simple tenotomy of the inferior oblique muscle would have remedied the situation immediately. Also, cases of high astigmatism may show head-tilting, which readily responds to the wearing of a corrective glass. In my experience, ocular torticollis is much more prevalent than is generally recognized.

As a passing suggestion, I would warn the pediatrician against the ophthalmologist who puts glasses on a child to correct a slight degree of astigmatism or hyperopia. Few eyes are refractively perfect, as the authors have said. A considerable degree of hyperopia is the rule in children, and they readily compensate for it. The stigma of "four eyes" on such children probably affects the personality complex much more than the supposedly corrective glass affects the visual impression.

On the other hand, the opposite point of view must be taken in cases of myopia, because lack of correction, or even undercorrection, not only affects the personality through limiting the visual impression, as the authors have mentioned, but may have a definitely harmful effect in allowing progression of an organic nature to take place. This is the opinion of most ophthalmologists. Whether the correction *per se* stops the progression, or the fact that the eyes are used less for close work with the glasses on, is debatable. In these cases the pediatrician can be of great help to the ophthalmologist in encouraging the families of myopic children to see that they wear their glasses all the time.

This paper is to be commended in emphasizing the mutual benefit to be derived in the coöperation of pediatrician with ophthalmologist.

MATERNAL AND CHILD WELFARE: ITS PROGRESS UNDER THE SOCIAL SECURITY ACT*

THE RELATION OF THE ACT TO OBSTETRICS IN CALIFORNIA

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DISCUSSION *by Howard Morrow, M.D., San Francisco; Karl L. Schaupp, M.D., San Francisco.*

THE necessity for some systematic effort to improve the standards for maternity care and the care of children has been generally recognized by both the laity and the medical profession for many years. Thus, as early as 1909, the first White House Conference on Child Welfare was called by the late President Theodore Roosevelt; this led, directly or indirectly, to various attempts to solve the problem.

In November, 1921, the act for the "promotion of the welfare and hygiene of maternity and infancy," popularly known as the Sheppard-Towner Act, became law. When the Act came to an end in 1929, forty-five states and the Territory of Hawaii were coöperating under its provisions, and public knowledge of the health problems of the infant and child and of the importance of adequate prenatal care had increased to a very marked extent.

SHEPPARD-TOWNER ACT

The Sheppard-Towner Act, great as were its benefits, was never wholly accepted or endorsed by physicians, and many times was violently opposed by the profession. As the author interprets this opposition, it was not due to a failure to recognize the necessity for promoting the objects of the Act, but rather to a sincere belief that a strictly medical problem was being undertaken by certain branches of government without affording the medical profession the opportunity to advise and coöperate in the undertaking. In other words, our profession felt that the undertaking was an attempt on the part of governmental agencies, largely nonprofessional in character, to assume professional prerogatives.

WHITE HOUSE CONFERENCE ON CHILD HEALTH AND PROTECTION

The White House Conference on Child Health and Protection, held in Washington in 1930, brought together what was probably the largest group ever assembled in the National Capital to consider the needs of mothers and children. A vast amount of data on child health and child welfare was assembled, and these reports led, directly or indirectly, to the presentation and adoption of legislation which the author believes will be of the greatest benefit to the mothers and children of the United States, as well as to our profession which is charged with the duty of providing for their medical care.

HOW FEDERAL AID IS ALLOCATED THROUGH THE SOCIAL SECURITY ACT

The Social Security Act (1935) authorizes federal aid to the states for certain phases of child health and welfare, including grants for aid for maternal and child-health services, for services for crippled children, and for child-welfare services. The particular activities which this society is interested in are those covered in and known as Title V, Part 1, maternal and child-health services, and only these will be discussed.

The administration of this part of the Act is under the immediate direction of a Maternal and Child Health Division of the Federal Children's Bureau, headed by a physician, and receiving general supervision from the assistant chief of the Children's Bureau, who also is a physician.

The distinction between Title V, Part 1, maternal and child-health services, and Title V, Part 3, child-welfare services, is well outlined in the stated purpose of each part. Thus, maternal and child-health services deal with the promotion of the *health* of mothers and children, while child-welfare services deal with the establishment of welfare services for the protection and care of homeless, dependent,

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and neglected children, and children in danger of becoming delinquent.

Under the provisions of the Act, each state or territory participating must submit a "state plan" which must conform with certain conditions. The conditions, which are of professional interest, are stated briefly as follows:

1. *Financial participation by the state.* The largest part of the federal allotment to each state must be "matched" by the state, but a smaller amount may be allotted outright, according to financial need for assistance in carrying out the state plan.

2. *Administration of the plan by the State Health Agency.* In California the administration has been made a function of the California State Board of Health, the actual administration being the responsibility of the Bureau of Child Hygiene, of which Dr. Ellen S. Stadtmuller is chief.

3. *Provision for extension and improvement of local maternal and child-health services.* You will note that this provision does not contemplate the duplication of existing local services, but provides only for their extension and improvement. It is the policy of the Federal Children's Bureau to proceed in such extensions and improvements *only* with the coöperation of the local medical and nursing organizations. It is not the intention of the Act, or of the Bureau, to act unless or until such coöperation is obtained.

4. *Provision for coöperation with medical, nursing, and welfare groups and organizations.* In California the report of the Committee of Maternal Welfare of the California Medical Association was submitted to the House of Delegates on May 24, 1936, and was adopted without discussion. The Committee recommended:

(*a*) That the Association endorse the plan of the Division of Maternal and Child Hygiene of the California State Board of Health, in connection with the Social Security Act.

This endorsement was predicated upon:

(1) Any change in the state plan must be submitted to this committee before becoming effective.

(2) That a systematic and widespread educational program in obstetrical problems for the general practitioner be instituted at once in coöperation with the State Board of Health.

5. Provision for development of demonstration services in needy areas and among groups in special need.

ADOPTION OF THE CALIFORNIA "PLAN"

The Bureau of Child Hygiene of the California State Board of Health submitted a "Proposed State Plan" to that Board on July 15, 1935, and the plan was adopted. The plan was then submitted to the Federal Children's Bureau, and was approved by the Chief of the Children's Bureau as conforming with the conditions of the Act.

OPERATION OF THE PLAN IN OTHER STATES

As of June 1, 1936, forty-three states (including California), the District of Columbia, Alaska, and Hawaii have qualified for these federal grants. Practically every state now has a Bureau of Maternal and Child Health with a medical director in charge. All state plans have one or more similar features aimed at the education of doctors, nurses, parents, and children in the care of the health of the mother and child. The Ohio plan, for instance, includes an educational program for county public-health nurses on maternal and child hygiene, an educational program for mothers' clubs, parent-teacher associations, and other organizations; preparation and distribution of literature, a demonstration program in setting up prenatal classes, infant-welfare stations, and preschool conferences; a monthly bulletin on maternal and child health; consultation services to health districts on maternal and child hygiene; investigations of maternal deaths; etc.

New Jersey is offering obstetric consultation services to physicians through the maternal-welfare commissions of the county medical societies.

I am quoting these two plans to emphasize the point that, under the Social Security Act, there is absolutely no plan of procedure which the individual states are expected to carry out. Instead, the local problems and their solution are expected to be outlined and solved by the local medical men.

In order to consider these local problems properly, the Children's Bureau suggested that each State Health Agency immediately appoint an Advisory Committee which should be composed of representative members of the various professions and agencies interested. The California State Board of Health appointed such a committee on February 15, 1936. Among the members representing our profession in obstetrics were Dr. Frank Lynch, Dr. Karl Schaupp, Dr. Thomas A. Card, and myself.

FEDERAL CHILDREN'S BUREAU ADVISORY COMMITTEE ON MATERNAL WELFARE

To advise with the Federal Children's Bureau in matters relating to the operation of the Act in so far as obstetrical problems were involved, an Advisory Committee on Maternal Welfare was appointed early in 1936. This committee is composed of Dr. Fred L. Adair, University of Chicago School of Medicine; Hazel Corbin, R.N., New York Maternity Center Association; Robert L. De Normandie, Boston; George W. Kosmak, Editor of the *American Journal of Obstetrics and Gynecology*; James R. McCord, Emory University School of Medicine; Lyle G. McNeile, University of Southern California School of Medicine; Alice N. Pickett, University of Louisville School of Medicine; E. D. Plass, State University of Iowa College of Medicine; and Philip F. Williams, University of Pennsylvania School of Medicine.

At the meeting of this Federal Advisory Committee, held in Washington, D. C., on March 14, 1936, the Committee, among other things, recommended:

1. That it seemed of paramount importance that the various state health officers, and those entrusted with activities under the Act, attempt in every possible way to

bring about the *active* coöperation of the medical profession in the application of these activities.

2. That one of the chief remedies for high maternal mortality and morbidity lies in the education of the medical profession, and that no state plan is complete unless it contains some provision for postgraduate education in obstetrics.

These recommendations were transmitted to the members of the Professional Advisory Committee of the State Board of Health, and to the California State Board of Health by me on March 25, 1936.

At the recent meeting of the Federal Children's Bureau Advisory Committee, held in Washington on March 20, 1937, the recommendations cover two special aspects of the program:

1. Increased maternity care and care of the new-born.

2. A program of training in these fields for physicians and nurses.

In adopting these recommendations, the Advisory Committee on Maternal and Child Health Services (a larger committee having general supervision over all of the various phases of these subjects) emphasized one phase as follows:

"The failure to use the Advisory Committees (by state health agencies) is jeopardizing the success of the plan in several states, which makes cooperation an important problem still to be solved."

PROGRESS IN THE OPERATION OF THE PLAN IN CALIFORNIA

As has already been stated, a proposed State plan for California was submitted to the California State Board of Public Health by the chief of its Bureau of Child Hygiene, Doctor Stadtmuller, on July 15, 1935, and after consideration and adoption by the Board, was submitted to the Federal Children's Bureau and approved as conforming with the required conditions. The plan outlined an extremely well-balanced program, of great interest and benefit to the medical and nursing professions of this State, and of inestimable value in promoting maternal and child health.

As of April 23, 1937, we find that an extremely well-rounded-out program for the care of the infant is in operation. The medical staff consists of seven full-time pediatricians whose districts cover the rural counties of the State. In addition, one full-time dentist has been placed upon the staff and has started a rural dental demonstration in Sutter County. The State Bureau now employs nine county nurses in the rural counties of California, a supervising nurse and a district supervising nurse, as well as three staff nurses engaged in the migratory and Mexican demonstrations. This portion of the plan is filling a definite need, and is being admirably carried out.

A beginning has been made in the establishment of prenatal care in those counties whose hospital care of indigents provides for care only at delivery. The State Bureau expects to extend this phase of the work as rapidly as possible.

"The California State Board of Public Health believes that the activities of its Bureau of Child Hygiene should be specially directed toward educating mothers to appreciate the services which the medical profession can render, and in advising, encouraging, and urging mothers to seek this medical protection."[1] It may be permissible to recall that this was the program under the Sheppard-Towner Act, and that the consensus of opinion, among those who are most familiar with the present conditions relating to maternal and child health, is that possibly its outstanding accomplishment was the education of the public in the appreciation of the health problems of the infant and child, and of the importance of adequate prenatal care. It is not the intention of the author to minimize the importance of such educational efforts, nor of any portion of the plan which has already been put into operation by the Bureau of Child Hygiene. It is, however, his desire to call the attention of the medical profession in California to certain fundamental omissions which have occurred in its operation, and to point out the great opportunities which the Act provides and which have not been utilized to any great extent in this State.

SPECIFIC INSTANCES IN WHICH THE PLAN IN CALIFORNIA HAS FAILED WHEN JUDGED BY ITS OPERATION IN OTHER STATES

This question can perhaps better be answered by quoting from the report of the Director of Maternal and Child Welfare Division of the Federal Children's Bureau, dated April 1, 1937, from the recommendations of the Advisory Committee on Maternal Welfare, and by comparing these facts with the progress made in California.

1. Although a Professional Advisory Committee of the California State Board of Public Health was appointed on February 15, 1936, no meeting of the Committee has ever been called. In some few instances, members of the Committee have been asked for their individual opinions, but no attempt has been made to encourage the discussion of the local and general problems by the Committee, which is composed of representatives of the medical and nursing professions and other interested agencies.

You will recall that I have already emphasized the finding of the Advisory Committee on Maternal and Child Health Services of the Federal Children's Bureau, which stated "the failure to use the Advisory Committees (by State health agencies) is jeopardizing the plan in several states."

2. Although on May 24, 1936, the California Medical Association adopted the report of its Committee on Maternal Welfare, which had endorsed the State plan, but predicated its endorsement upon (1) changes in the State plan's being submitted to the Committee before becoming effective, and (2) the immediate institution of a systematic and widespread educational program in obstetrical problems for the general practitioner, absolutely no attempt has been made to date to begin such an undertaking.

Of the other states, forty-one states and Hawaii are conducting postgraduate courses in obstetrics and pediatrics for local physicians. Fourteen states have used lecturers from their own states; six have used local and out-of-state lecturers; twelve states and Hawaii have requested their lecturers from out

of the state; and eight states have twelve full-time lecturers on their staffs (of which five are pediatricians and seven are obstetricians).

This failure is particularly significant and inexcusable, when one considers that the Committee on Postgraduate Activities of the California Medical Association, composed of Dr. Clarence G. Toland, Dr. John C. Ruddock, Dr. F. F. Gundrum, and the Secretary of the Association, has outlined a comprehensive program and has facilities for putting it in operation should a request be made.

Even the nursing education program, which was most admirably outlined in October, 1936, for which a teaching staff had been selected, and which was scheduled to be given in ten localities throughout the State during November, January, March, and May was canceled. No reason was given.

In the Federal Director's report, already mentioned in speaking of the program in other states, he remarks: "The coöperation between the state departments of health and the state medical societies which has been shown in carrying out this educational work has, in many states, brought about a more friendly feeling between these two groups than had existed in the past. No portion of the program has been more enthusiastically received."

Many of you will wish to learn more about the actual operation of the Act in California than can be profitably given in a paper prepared for a meeting of this section. For those, the author recommends reading a paper by Dr. Ellen S. Stadtmuller, Chief of the Bureau of Child Hygiene of the California State Board of Health, on "The Social Security Act: Maternal and Child Health." This paper will be read before the Pediatric Section at this session of the California Medical Association.

CONCLUSIONS

1. The maternal mortality rate in California has declined from 6.0 per thousand live births in 1925 to 4.5 in 1935.[2] During this period the death rates from sepsis have remained constant, the decline having occurred in the group "puerperal causes other than sepsis." This 1935 figure of 4.5 per thousand live births compares very favorably with the rate of 5.8 per thousand for the entire United States. The foremost authorities in this country feel, however, that the low mortality rate of 3.5 per thousand, the rate of some foreign countries, could be attained if the medical profession would earnestly and conscientiously make a systematic effort to lower our mortality.

2. Under Title V, Part 1, of the Social Security Act of 1935, opportunity has been afforded the medical profession of the various states and other governmental subdivisions to institute, and actively participate in, the improvement of conditions which they, the profession, believe should solve their local problems.

3. The most important factor which will insure the success of this program is the active coöperation between the state health agency (in California, the State Board of Public Health), the medical profession, and other interested agencies. The Children's Bureau, through their Advisory Committees, believe that this can be accomplished through the constant use of the state health agencies' "Professional Advisory Committees."

4. The most outstanding faults in the operation of the plan in California have apparently been the failure of the State Board of Public Health to make any use of its Professional Advisory Committee, and the loss of time in instituting a systematic and widespread educational program in obstetrical problems for the general practitioner.

5. A true spirit of active coöperation between the California Board of Public Health and the California Medical Association has existed for many years.

The author believes that if the medical profession of this State would indicate its great interest in the successful operation of the portion of the Social Security Act relating to Maternal and Child Health, the State Board of Public Health will, in turn, become more aggressive in extending its activities under the Act.

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REFERENCES

1. Quotation from paper by Ellen S. Stadtmuller, read before the Pediatric Section of the California Medical Association at Del Monte on May 5, 1937.

2. Figures compiled by the United States Bureau of Census, from official sources.

DISCUSSION

HOWARD MORROW, M.D. (384 Post Street, San Francisco).—The author's criticisms are hardly justified, as they do not take into account the California laws on the expenditure of public moneys. No money is available to defray traveling expenses of physicians or other citizens who are not employees in the legal sense.

Members of advisory committees are used for advice and are not legal employees. Letters of advice from members of advisory committees are always welcome, and are given careful consideration.

The Board of Public Health must maintain supervision of its bureaus and employees, and the orders must come from one source. Consequently, advisory committees and members of advisory committees must send their recommendations direct to the Board, which will then instruct the Director of Public Health to give such orders as are necessary to the chiefs of the bureaus.

The Board is willing, at all times, to inaugurate any methods when it is convinced that the suggested procedures will not jeopardize the public health nor the rights of physicians in private practice.

KARL L. SCHAUPP, M.D. (490 Post Street, San Francisco).—It is not necessary to say much in discussing Doctor McNeile's paper, for he has covered the field very thoroughly and fairly.

It is true that the Professional Advisory Committee was not used very much earlier in the development of the program, but that has now been remedied. The State Board of Health, through Doctor Stadtmuller, its Director of Maternal Welfare, in coöperation with the Advisory Committee, has now a very practical plan which will do much toward helping to solve the problem. Under the proposed plan there will be the fullest coöperation with obstetricians as well as the general practitioner in the communities which are to be served.

I feel that the success of any such plan, which no doubt is needed, will depend directly upon the coöperation of the medical profession.